INSPIRED ORTHODONTICS

REFERRAL

DR. BOCKOW | DR. TRUONG

REFERRING DOCTOR: **TEL:**

PATIENT: **DATE:**

AGE: **GENDER:** **DATE OF BIRTH:**

TEL: **WORK TEL:**

EMAIL:

SCHEDULING

☐ **SEATTLE LOCATION**

509 OLIVE WAY, SUITE 840
SEATTLE, WA 98101

P: (206) 623-2192

E: SMILESEATTLE@INSPIREDORTHO.COM

☐ **BELLEVUE LOCATION**

1200 112TH AVE NE, SUITE B-200
BELLEVUE, WA 98004

P: (425) 453-0551

E: SMILEBELLEVUE@INSPIREDORTHO.COM

☐ PATIENT WILL CALL TO SCHEDULE ☐ PLEASE CALL PATIENT TO SCHEDULE AN APPOINTMENT

DATE OF LAST CLEANING _____

AREAS OF CONCERN

☐ UNDERBITE ☐ OVERBITE ☐ CROSSBITE

☐ CROWDING ☐ SPACING ☐ AIRWAY / SLEEP

☐ IMPACTED TOOTH ☐ PRE-RESTORATIVE ☐ JAW SURGERY

☐ OTHER _____

RESTORATIVE TREATMENT

☐ IS COMPLETED ☐ IS UNDERWAY ☐ IS PENDING OUTCOME OF ORTHODONTIC FINDINGS

XRAYS

☐ FMX AVAILABLE
DATE:_____

☐ PANORAMIC AVAILABLE
DATE:_____

☐ CBCT AVAILABLE
DATE:_____

COMMENTS

_____

_____

_____

_____

SLEEP, BREATHE, SMILE

LIFE CHANGING CARE

– TWO CONVENIENT LOCATIONS –

SEATTLE
509 Olive Way, Suite 840
Seattle, WA 98101
p: (206) 623-2192
e: SmileSeattle@inspiredortho.com

BELLEVUE
1200 112th Ave NE, Suite B-200
Bellevue, WA 98004
p: (425) 453-0551
e: SmileBellevue@inspiredortho.com